

Dr Slater is wrong when he states that "Wright<sup>3</sup> estimated that a 1°C rise in temperature will increase the estimated blood alcohol concentration by 6.5%." Careful scrutiny of Wright's paper shows that he made no such claim. However, in the same proceedings Dubowski<sup>4</sup> stated that "it may be well to point out that each 1°C increase in actual alveolar breath exit temperature between 34°C and 37°C would tend to increase a blood alcohol concentration calculated on the basis of an assumed 1:2100 ratio by about 6.5% over the actual level." Presumably it was to this statement that Dr Slater intended to refer.

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<sup>1</sup> Alobaidi, T A A, and Hill, D W, *Journal of Physics E*, 1975, 8, 30.

<sup>2</sup> Payne, J P, Hill, D W, and King, N W, *British Medical Journal*, 1966, 1, 196.

<sup>3</sup> Wright, B M, in *Proceedings of the Third International Conference on Alcohol and Road Traffic*, p 251. London, British Medical Association, 1963.

<sup>4</sup> Dubowski, K M, in *Proceedings of the Third International Conference on Alcohol and Road Traffic*, p 203. London, British Medical Association, 1963.

### Smallpox vaccination for students?

SIR,—I am sometimes asked to give smallpox vaccination to students before university entry. They do not seem to be in any special risk category. My explanation that the risks probably outweigh the advantages unless they plan a trip to Ethiopia is not always well received. Sometimes vaccination is demanded "because the university says I need it."

It is interesting to contrast this attitude with that of some parents to infant immunisation. "Official" recommendations are that the benefits outweigh the risks, even for the highly publicised pertussis vaccine. Yet many children go totally unimmunised for fear of brain damage. In view of current public concern about the safety of vaccines, perhaps those universities advising students to be vaccinated against smallpox should revise their requirements before there is hue and cry about the unnecessary risks our "best brains" are being subjected to.

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### Haematemesis and melaena

SIR,—In their useful summary of the management of acute gastrointestinal haemorrhage Dr P B Cotton and Mr R C G Russell (1 January, p 37) refer to the difficulty which all surgeons experience in identifying those patients who need urgent operation. The patients most at risk are those who continue to bleed, or who recommence bleeding, after admission to hospital and I have found the figures collected here some years ago<sup>1</sup> to be of great practical value.

Among 817 consecutive admissions for acute alimentary bleeding there were 229 episodes of further haemorrhage (FH) after admission to the wards. This group had a mortality of 28.8% compared with 7.8% among those who did not bleed significantly after admission. These figures highlight the significance of FH after admission. Its adverse effect was felt among those with haematemesis and with melaena. It was more dangerous if it occurred more than 48 h after admission

rather than during the first two days. Emergency surgery had to be performed on 66% of patients whose FH came from a peptic ulcer and who were bleeding more than 24 h after admission. At St James's Hospital, Balham, it was found<sup>2</sup> that emergency surgery performed on the day of admission carried a mortality of 14% but that this rose to 33% on the fourth day and to 52% when operation was delayed until the seventh day after admission.

These results underline how vital is the advice of Dr Cotton and Mr Russell to observe these patients very closely, in the best possible circumstances, so that evidence of FH can be promptly detected. Once obtained, this evidence places these patients immediately into a group which, irrespective of age, is at very high risk.<sup>3</sup> This is the moment for the physician to consult with the surgeon and, with these figures in mind, the surgeon may find it easier to make a decision. The evidence shows unmistakably the penalties of delay.

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<sup>1</sup> Jones, P F, *et al*, *British Medical Journal*, 1973, 3, 660.

<sup>2</sup> Cocks, J R, *et al*, *Gut*, 1972, 13, 331.

<sup>3</sup> Needham, C D, and McConachie, J A, *British Medical Journal*, 1950, 2, 133.

### Renal arterial disease and accelerated hypertension

SIR,—In the paper by Drs R D Thomas and M R Lee on sodium repletion and beta-adrenergic blockade in the treatment of salt depletion with accelerated hypertension (11 December, p 1425) I notice with interest that the patient was a man aged 60 years who was found to have a totally occluded left main renal artery.

Having been especially interested in hypertension for over 30 years I can remember only four patients aged 60 and above who presented with accelerated or frankly malignant hypertension. The first one had no special studies done; he was aged 74 whom I did not think it worth while to investigate, perhaps wrongly. The other three all had unilateral renal disease—a complete renal artery block in two cases and a significant main renal artery stenosis in the third. All patients had rather low potassium and serum sodium concentrations, as is common in secondary accelerated hypertension. In two patients resection of the non-functioning kidney led to a fall in blood pressure to levels around 180/100 mm Hg, which were probably present before the renal artery occlusion occurred and were the expression of a simple essential hypertension which required no treatment. The last patient was referred elsewhere with a view to a bypass graft but instead was treated medically—this not without initial troubles, as is to be expected in hypotensive treatment in the elderly.

Although renal investigation of hypertension rarely yields profitable results I would make an exception in the case of accelerated and malignant hypertension in the elderly. If renal artery occlusion or severe stenosis is found I think that there is a strong case for surgery, as medical treatment in the elderly can be difficult and the patients do not stand to lose much by the ablation of a non-functioning or very poorly functioning kidney.

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### Need for improvement in dermatology services

SIR,—I would like to link up the paper on the National Eczema Society by Mr John Launer (18 December, p 1494) with the letter on economies through improved dermatological services from Dr H R Vickers (1 January, p 46).

The National Eczema Society, the Psoriasis Society, the Cosmetic Camouflage Society, and any other such organisation which may exist unknown to me all have one interest in common, the improvement of the dermatological services throughout the country. The usual management technique which assesses and order of priority between different specialities and then allocates the inadequate resources available has a built-in defect. The acute services of medicine and surgery always come top and specialities such as dermatology always come near the bottom and get little financial support.

It is a constant up-hill battle for a consultant dermatologist in the periphery to get proper facilities for his patients, especially if he is involved in more than one administrative area. In South Wales the appointment of a consultant dermatologist to serve the whole of the country west of Swansea has repeatedly been deferred over many years. A recent appointment at Newport due to retirement failed to attract a suitable candidate. In both situations there has been failure to provide adequate facilities to organise a modern dermatology service.

Patients with skin diseases suffer but seldom die in dramatic fashion. They are also reticent about their complaints and do not seek publicity. It would be of value if these individual organisations could combine to speak on behalf of all sufferers from skin disease. It is only through a vocal public demand that improvement of services is likely to occur.

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### Neonatal respiratory intensive care at local level

SIR,—We write in reply to the letter from Drs J M Davies and Janet L P Hunter (25 December, p 1557) about referral units for newborn babies requiring intensive care.

While we would agree that there is much to be said for all units administering oxygen to premature babies being able to measure at least the concentrations in incubators if not the tension in arterial blood, it is our belief that the artificial ventilation of such babies should as a rule be attempted only in units staffed and equipped for intensive care. Respiratory intensive care is very expensive in terms of man and woman power and equipment and is not done well or economically on an occasional basis. A region can keep such a unit busy with good return on capital in terms of lives saved and morbidity prevented; a maternity hospital cannot unless very large and itself a referral unit. In a small unit concentration of concern on very ill babies is only too likely to lead to relative neglect of others and to an overall increase in mortality and morbidity.

There is much that peripheral units can do for vulnerable newborn infants which will reduce the incidence of and mortality from